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From the NIS to the NHS via the Floating Sixpence

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In our new series on the history of prescribing policy, Professor Darrin Baines traces how successive governments have attempted to curb drug costs. Here, he outlines some of the measures introduced in the earliest days.

KEY EVENTS

- 1911 The National Insurance Act provided medical benefits for workers earning under £160 per year who paid four pence a week to the scheme
- 1913 National Insurance Scheme introduced – the UK's first health insurance scheme
- 1913 The Floating Sixpence was intended to control the cost of prescribed medicines
- 1948 National Health Service introduced – healthcare, free at the point of delivery, became available for the first time to the UK's population, including free pharmaceutical services
- 1952 First major study on prescribing variations – Dunlop's study began the process of analysing NHS prescribing patterns in a scientific manner and identified variations between demographic areas, prescribing doctors and drug choice

The 1911 National Insurance Act outlined legislation to give wage earners access to a scheme for covering themselves in sickness and ill-health. Part I of the Act provided insurance with medical benefits for workers earning under £160 per year, with personal and employer contributions.

The scheme worked on a 'nine pence for four pence' basis, with individuals paying four pence a week, employers three pence and the government two. Those covered could receive limited sick pay and care from a 'panel' doctor.

The National Insurance Scheme

Prior to the introduction of the National Insurance Scheme (NIS) in 1913, family doctors in industrial areas often self-dispensed the drugs that they prescribed to their low-income patients. However, under the NIS urban doctors frequently wrote a 'script' for the products that their patients required that could be cashed at any pharmacy on the local 'pharmaceutical list'.

As a result of this change, the involvement of urban doctors in dispensing substantially diminished and pharmacists began to supply the bulk of medicines prescribed. In rural areas, on the other hand, practitioners often had to self-dispense the items that they prescribed because of an absence of pharmacies in their localities.[1] In consequence, the range and volume of medicines received by rural patients were often limited by the products that 'dispensing doctors' decided (or could afford) to stock.

Under the NIS, doctors received a payment for each insured patient on their lists, while pharmacists received a fee for each item that they dispensed. In consequence, neither party had an incentive to limit the total number of drugs supplied as high-volume prescribers were likely to attract more patients to their practices and pharmacists who supplied more items earned higher dispensing incomes.

Although this situation may have been welcomed by some, increases in spending on prescribing and dispensing created problems for the administrators of the NIS as panel expenditures had to be contained within the strict spending limits set by the government.

Measures to curtail expenditure

As a means of controlling costs and enhancing the quality of prescribing

Year	Proportion of all items supplied	Proportion of overall spend
1947	7.0%	24.0%
1950	18.0%	44.0%
1956	40.5%	66.0%
1957	48.0%	70.0%

Table 1. Proportion of branded drugs prescribed, 1947–57 (after reference 2). After the war many more branded medicines became available, increasing prescribing costs

under the NIS, the administrators of the scheme introduced a number of measures designed to improve the information available to participating doctors and to curtail the expenditure of the highest-cost prescribers.[2]

For example, copies of the *National Formulary* were distributed free to all panel doctors. Also, regional medical officers (working for the Ministry of Health) were instructed to visit the highest-cost practitioners in each area. Following an appropriate investigation, the Minister of Health could reduce the remuneration of excessive prescribers.[3]

While these measures were designed to improve prescribing under the panel, except in the most extreme cases they relied upon the goodwill of the doctors involved.

For instance, the *National Formulary* could only improve prescribing if doctors responded to its contents; regional medical officers could only advise high-cost prescribers to reduce their spending; and the Minister of Health could only penalise practitioners with excessive expenditure levels.

In consequence, other means of improving the prescribing behaviour of nonexcessive GPs had to be found.

The Floating Sixpence

In an attempt to limit the total amount that panel doctors spent on prescribed drugs, a hybrid incentive and discounting scheme, commonly referred to as the Floating Sixpence, was introduced.[2]

Under the scheme, if *per capita* expenditure on pharmaceuticals in any area fell below the average capitation payment of two shillings per person per year, the short-fall (of up to a maximum of sixpence per head) was added to the remuneration of the local panel doctors.

However, if expenditure exceeded two shillings per head, the payments given to local pharmacists were reduced as a means of controlling overall costs.

Although the Floating Sixpence was designed to control total spending on pharmaceuticals, the scheme was seen as unsatisfactory by many and, consequently, was abolished in 1920.

The NHS begins

Introduced in 1948, the National Health Service (NHS) experienced many of the problems encountered by the NIS but to a greater degree because the whole population (not just insured workers) were provided healthcare free at the point of delivery.

As was the case with general practice as a whole, the arrangements for prescribing and dispensing drugs initially chosen for the NHS were based upon those originally employed under the NIS. Indeed, under the new system most drugs were prescribed by a GP, the majority of products were supplied by a pharmacist, and rural practices could apply to self-dispense medicines to their patients living over one mile from a pharmacy.

Similarly, under the NHS, pharmacists received a fee for each item that they dispensed and were reimbursed at nationally agreed rates for the products that they provided. Dispensing doctors, on the other hand, could choose to be remunerated and reimbursed on the same basis as pharmacists or to receive a capitation fee designed to cover the majority of the costs of the products that they supplied.

	Residential	Industrial	Suburban	Total
Brands	1 455 (27%)	1 323 (21%)	790 (14%)	3 568 (21%)
Generics	3 821 (73%)	4 985 (79%)	4 927 (86%)	13 733 (79%)
Total	5 276	6 308	5 717	17 301

Table 2. Regional variations in branded prescribing, September 1949 (after reference 4)

Although it adopted arrangements similar to those employed under the NIS, the new body responsible for pricing prescriptions and reimbursing pharmacists within the NHS, the Joint Pricing Committee, initially found it difficult to cope with the demand for its services.

In part, the committee's problems were caused by a backlog of 60 million prescriptions that had not been processed during the Second World War and a doubling in the number of scrips that were dispensed due to the introduction of the NHS.

As a result of the overwhelming demand for its services, the body was unable to reimburse pharmacists and dispensing doctors for all of the items that they supplied.

Even though they were effective at delivering the products that patients required, the prescribing and dispensing systems originally chosen for the NHS embodied few mechanisms that automatically controlled public expenditure on drugs.

For example, the arrangements for prescribing did little to limit the volume of medicines that GPs prescribed. The arrangements for dispensing, on the other hand, gave pharmacists few incentives to advise local practices on how to improve their use of available pharmaceutical products.

In consequence, other measures had to be introduced in an attempt to control the growth and variation in general practice prescribing volumes and costs.

Given the similarities in the prescribing and dispensing systems that the two schemes employed, many of the measures originally introduced to improve prescribing within the NHS were similar to those used under the NIS. For example, the *British National Formulary* (*BNF*) was distributed free to all GPs, high-cost prescribers were visited by a regional medical officer, and a system for investigating

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and penalising excessive prescribing was introduced.[3]

Despite the similarities, memories of the inadequacies of the Floating Sixpence meant that a prescribing budget or incentive scheme was not introduced.

Brand prescribing

The NHS was introduced during a period of 'scientific revolution' in pharmacy, in which many new pharmaceutical products (which could not be manufactured outside of a factory by pharmacists or dispensing doctors) were developed and the range of drugs available to treat each medical condition was greatly extended.[3] In consequence, from July 1948 onwards, family doctors were able to prescribe a wider range of products (many of which were more expensive than existing generic preparations) than had been possible under the NIS.

As Table 1 shows, the introduction of the NHS at a time of major pharmaceutical innovation led to a rapid increase in brand prescribing rates and costs that the administrators of the system found difficult to control.[2]

Regional variations

The introduction of the NHS also led to considerable variations in brand prescribing rates between different demographic areas in England.[4] As Table 2 shows, using a sample of 17 301 scrips dispensed during September 1949, practices in places classed as 'residential' used a higher proportion of branded preparations than in those classed as 'industrial'. In turn, practices in industrial areas used proportionally more branded products than those in 'suburban' regions.

Although a demographic pattern was identified, the observed differences were considered to be probably 'due more to the prescribing habits of the doctors concerned than to the social groups catered for – a situation which would almost certainly had been very different had the analysis been prior to the National Health Service Act'.

References

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The next article in this series will look at the introduction of the prescription charge and the *Drug Tariff*.

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